STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105549	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at the Harbor	1410 Dr Martin Luther King Jr St N Safety Harbor, FL 34695

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the rights of a resident representative, appointed as the Guardian Advocate and authorized to consent to medical treatment, were honored related to communication of health status for one resident (#1) of five sampled residents.Findings included: On 06/10/2026 at 4:52 p.m., a telephone interview was conducted with Resident #1's family member. She reported that she had been appointed as the resident's Guardian Advocate in October 2025 and had provided the appointment paperwork to the Admissions Director at the time of the resident's admission. She stated she repeatedly contacted the facility for health updates but never received a return call. She reported that she had not signed any informed consents for psychotropic medications. She stated that a visitor went to the facility and shared concerns about the resident's care. On 05/13/2026, she personally went to the facility, found the resident lethargic and not at baseline, and requested the resident be transferred to the hospital. The resident was subsequently transferred and received care. She stated the resident now lives in a supported living program where communication is consistent and the resident is receiving better care than she had in any nursing home.A review of Resident #1's clinical record showed an admission date of 04/23/2026 and discharge on [DATE]. The face sheet identified the same family member as Emergency Contact #1 and Guardian, with a phone number and email listed. Resident diagnoses included malfunction of a continent urinary stoma, muscle weakness, MRSA infection, neuromuscular bladder dysfunction, fibromyalgia, chronic pain syndrome, stage 3 pressure ulcers, and spina bifida. Guardianship paperwork was scanned into the record on 04/23/2026. The Letters of Guardian Advocate from the Sixth Judicial Circuit, [Name of county] County, appointed the family member as Guardian Advocate with the authority to consent to medical treatment. The document was ordered and signed on 10/21/2025.A review of the Care Plan revealed no advance directive care plan for Resident #1.A review of nursing progress notes dated 04/23/2026 through 05/12/2026 showed no documentation of communication with the Guardian Advocate regarding multiple refusals of wound care, medications, assessments, or episodes of behavioral changes. Notes documented repeated refusals of care, wound care, routine medications, vital signs, labs, and evaluations. On 05/01/26, 05/02/26/ 05/03/26, 05/04/26, 05/05/26 and 05/12/2026, staff documented frequent behavioral episodes, including screaming, refusing care, refusing medications, and combativeness. The Director of Nursing (DON) was informed, and the resident was evaluated by in house Advanced Practical Registered Nurse (APRN) and wound care APRN. A request was made for a psychiatric evaluation, which was not completed that shift. The resident refused transfer to the emergency room when offered. There was no evidence that the Guardian Advocate was notified at any time regarding these changes or concerns.During an interview on 06/10/2026 at 2:07 p.m. with the Nursing Home Administrator (NHA) and the Registered Nurse Consultant, the NHA stated that he had reviewed the guardian paperwork at admission but believed the facility needed a determination of incapacity. When asked whether he contacted the facility's legal department for guidance, he stated he had not. A review of the facility's policy titled Advance Directives, SS 124, last revised 11/14/2018, states that the center will abide by state and federal laws regarding advance directives and will honor all properly executed advance directives provided by the resident or resident representative.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the legally appointed Guardian Advocate was notified of and involved in health care decisions, including the use of psychotropic medications, for one resident (#1) of five sampled residents.Findings included:On 06/10/2026 at 4:52 p.m., a phone interview was conducted with Resident #1's family member. The family member stated they had been appointed Guardian Advocate in 10/2025 and had provided a copy of the appointment letter to the Admissions Director at the time of admission. They reported repeatedly calling the facility for updates on the resident's condition but never received a return call. They stated they did not sign any informed consent forms for psychotropic medications. The family member reported that a visitor had expressed concerns about Resident #1's care. On 05/13/2026, upon visiting the facility, the family member found the resident lethargic and not at baseline. They requested the resident be sent to the hospital, and the resident was subsequently transferred. The family member reported that Resident #1 is now in a supported living setting with significantly improved communication and care.Record review revealed Resident #1 was admitted on [DATE] and discharged on 05/13/2026. The face sheet listed the same family member as the #1 Emergency Contact/Guardian, with phone number and email. The resident's emergency contact listed the same family member identified in the guardianship paperwork as the #1 contact/guardian, with both phone number and email provided. The diagnosis list included multiple conditions, including malfunction of urinary tract stoma, neuromuscular dysfunction of the bladder, fibromyalgia, chronic pain syndrome, and pressure ulcers (all onset dated 04/23/2026).Review of the Guardianship paperwork scanned into the electronic chart on 04/23/2026 revealed the court documents from the Sixth Judicial Circuit, [Name of County] County, appointed the family member as Guardian Advocate with the authority to consent to medical treatment, ordered 10/21/2025.Review of the Consent to Treat dated 04/23/2026 showed the resident's name written in the resident signature field, an illegible facility representative signature, and a blank responsible party section.Review of psychotropic medication informed consent forms dated 04/23/2026 for: Buspar (anti anxiety), Seroquel (antipsychotic), and Trazodone (antidepressant)revealed each form was signed in person by the resident. No guardian signature was present on any form.Review of Medication Administration Record (MAR) showed: Ativan 2 mg/mL IM given on 04/28/2026 and again on 05/13/2026 without informed consent in the record. Hydroxyzine 50 mg administered on 05/04, 05/05, 05/08, and 05/10 without informed consent in the record.During the survey, the facility was unable to produce completed informed consent forms for Ativan or Hydroxyzine, despite request.On 06/10/2026 at 1:20 p.m., the Registered Nurse Consultant (RNC) stated that informed consent for psychotropic medication is typically required from a resident's guardian.On 06/10/2026 at 2:07 p.m., during an interview with the Nursing Home Administrator (NHA) and the RNC, the NHA stated he had reviewed the guardianship paperwork at admission but believed an incapacity decision was required before involving the guardian. When asked if he consulted the facility's legal department, the NHA stated, No, I did not.Review of the facility's Medication Management - Psychotropic Medications policy (revised 04/28/2025) states that risks and benefits must be reviewed and consent completed prior to initiating psychotropic medication.The Advance Directives policy (revised 11/14/2018) requires the facility to honor all properly executed directives provided by the resident or representative.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interviews, the facility failed to develop and implement a baseline care plan within 48 hours of admission to address Advance Directives and person-centered care for one resident (#1) of five sampled residents.Findings included: Record review of Resident #1's clinical record showed an admission date of 04/23/2026 and a discharge date of 05/13/2026. The face sheet identified the resident's primary emergency contact as a family member who was also listed as Guardian Advocate, with a home phone number and email address.Resident #1's diagnoses included: malfunction of continent stoma of urinary tract; muscle weakness; methicillin resistant Staphylococcus aureus infection; neuromuscular dysfunction of bladder; fibromyalgia; chronic pain syndrome; pressure ulcer of left hip, stage 3; pressure ulcer of other site, stage 3; and spina bifida, unspecified. Onset dates for the latter diagnoses were 04/23/2026.Review of the documents scanned into the clinical record showed Letters of Guardian Advocate uploaded on 04/23/2026. The legal document, issued by the Circuit Court of the Sixth Judicial Circuit, [Name of County] County, Florida, Probate Division, dated 10/21/2025, verified that the listed family member had been appointed Guardian Advocate for Resident #1 with authority that included consent for medical treatment.Review of the electronic care plan system revealed no advance directives care plan for Resident #1.On 06/10/2026 at 4:52 p.m., a phone interview was conducted with Resident #1's family member, who stated she had been appointed Guardian Advocate in 10/2025. She reported that she provided the appointment documents to the Admissions Director at the time of admission. The family member stated she called the facility repeatedly to obtain updates regarding Resident #1's condition but did not receive return calls.On 06/10/2026 at 2:07 p.m., an interview with the Nursing Home Administrator (NHA) and the Regional Nurse Consultant (RNC) revealed the NHA had reviewed the guardian documentation at admission but stated, I thought we needed an incapacity decision. The NHA confirmed the facility had access to a legal department for assistance with document interpretation but stated he did not contact them for guidance in this case.On 06/10/2026 at approximately 3:08 p.m., an interview with the Minimum Data Set (MDS) Coordinator, Registered Nurse, revealed Resident #1 had discharged prior to completion of the comprehensive care plan. Review of the electronic care plan confirmed no advance directives focus area. The MDS Coordinator stated Social Services was responsible for developing the advance directives care plan and verified that the baseline care plan, which would contain the information, was not available in the system.During an interview on 06/10/2026 at 4:16 p.m., the NHA stated the facility had not been able to locate Resident #1's baseline care plan.Review of the facility's Plans of Care policy (N 1015), effective 11/30/2014, documented that an individualized person centered plan of care is to be developed by the interdisciplinary team with the resident and/or representative. The policy required staff to develop and implement a person centered baseline care plan within 48 hours of admission that includes initial goals and information from admission orders, physician orders, dietary orders, therapy services, social services, PASRR recommendations (if applicable), and other areas needed to ensure effective and appropriate care until the comprehensive care plan is completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to develop and implement a comprehensive, person centered care plan addressing hearing impairment and hearing aid management for one resident (#2) out of five residents sampled.Findings included: On 06/10/2026 at 9:32 a.m., Resident #2 was observed sitting on the side of her bed, partially through her breakfast meal, and wearing a hospital gown. The resident stated she had lost both hearing aids-one had been missing a while and the second was now gone. A landline telephone was on her bedside table. The resident could not recall when either hearing aid went missing.Record review showed that Resident #2 was admitted on [DATE]. Her face sheet listed a family contact. Diagnoses included muscle weakness, hypothyroidism, glaucoma, and hypertension. The personal effects inventory dated 01/01/2026 documented one pair of hearing aids.A review of the care plan on 06/10/2026 identified a focus area related to altered self care performance due to emphysema, glaucoma, and dementia, with interventions requiring assistance for personal hygiene and upper body dressing. However, the care plan contained no focus area or interventions addressing the resident's hearing impairment, hearing aid use, or related staff support.On 06/10/2026 at approximately 11:50 a.m., the Nursing Home Administrator (NHA) stated they were responsible for grievances but were unaware the resident's hearing aids were missing.On 06/10/ 2026 at 12:09 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). Staff A (LPN) reported being familiar with Resident #2 but stated, I do not perform that function regarding placing hearing aids in the resident's ears. Staff A believed CNAs (Certified Nursing Assistants) usually assisted but was unaware the devices were missing until asked by the Administrator approximately 25 minutes earlier. Staff A then initiated a grievance.On 06/10/2026 an 12:41 a.m., Staff B (CNA) stated he was assigned to Resident #2 on the 7 a.m.-3 p.m. shift. He said the resident stayed in bed frequently but sometimes got up for music or activities. He confirmed the resident had hearing aids but stated, I do not put them in. The staff from the 11 p.m.-7 a.m. shift put them in. He reported he did not know they were missing. The hearing aid case on the bedside table was observed to be empty.On 06/10/2026 at 1:30 p.m., a phone interview with the resident's family member revealed that the resident had told him a couple of days prior that one hearing aid was missing. He stated that, as far as he knew, she had both hearing aids before that time. During an interview and review on 06/10/2026 at 3:08 p.m., the MDS Coordinator reviewed the care plan and MDS assessments stating as follows: 01/13/26 admission MDS: highly impaired hearing, no hearing aids 01/27/26 quarterly MDS: highly impaired hearing, no hearing aids 04/29/26 quarterly MDS: highly impaired hearing, yes to hearing aidsThe MDS Coordinator stated that the hearing related care plan did not trigger because the full assessment did not capture the presence of hearing aids. She confirmed that the resident's chart listed Special Instructions stating: Please remove and charge hearing aids every night. She stated nurses were responsible for this task, but the clinical record contained no documentation that nurses performed it. She also stated that hearing aid support was not included in CNA task lists. A review of the facility's Plan of Care Policy (N 1015, effective 11/30/2014) showed an individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/ or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Plan of care is to be maintained as part of the final medical record. The Procedure showed an expectation to: -Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Review, update or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA (Omnibus Budget Reconciliation Act) MDS assessment (except (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.